

SC DHEC DIVISION - IN-SERVICE TRAINING PROGRAM
EMT-INTERMEDIATE RE-CERTIFICATION REQUEST

SC EMT-Intermediate Certification Number: _____ Expiration Date _____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number + Area Code: _____ E-Mail: _____

_____ Yes _____ No *Since your last re-certification, have you been convicted of a felony? If **yes**, you must provide official documentation that fully describes the offence, current status and disposition of the case.*

SC Licensed EMS Provider whose IST program you are affiliated with: _____

SECTION I: Didactic Requirements

Date Completed	Divisions	Hours Required	Hours Earned
	Preparatory	6	
	Airway Management & Vent.	6	
	Patient Assessment	0	
	Trauma	10	
	Medical	18	
	Special Considerations	6	
	Operations	2	
	Total Hours	48	

SECTION II: Skill Verification Competency verified by Training Officer (T.O.) -or- Medical Control Physician (M.D.)

Skills	Verified by T.O.	Verified by M.D.
Patient Assessment / Management <i>(Medical & Trauma)</i>		
Ventilatory Management Skills / Knowledge <i>(Simple Adjuncts, Supplemental Oxygen, BVM one & two rescuer, LMA, Oral Suction, Intubation, Dual Lumen, Sterile Suction)</i>		
Cardiac Arrest Management <i>(Adult CPR one & two rescuer, Child CPR, Infant CPR, Adult, Child & Infant Obstructed Airway, AED)</i>		
Hemorrhage Control & Splinting Procedures <i>(Direct Pressure, Pressure Point, Tourniquet, PASG, Upper & Lower Extremities)</i>		
Spinal Immobilization <i>(Seated & Lying Patients)</i>		

Skills	Verified by T.O.	Verified by M.D,
OB / Gynecologic Skills / Knowledge		
Other Related Skills / Knowledge (<i>BGL Monitoring, Assisted Meds, Administered Meds, IV & IO, Patient Lifting/Stretcher Handling, Radio Communications, Report Writing & Documentation</i>)		

SECTION III: Attendance Requirements List the **Month & Year** each time this individual attended an IST class.

EMT Certification Year One From _____ To _____	EMT Certification Year Two From _____ To _____	EMT Certification Year Three From _____ To _____

SECTION IV: BLS Credential

Place a **copy** of the individual's BLS **card** in the appropriate block.

A copy of the card or roster is required!

<p>BLS Credential Here</p> <p>Must be ONE of the following: (<i>Provider or Instructor</i>)</p> <p>Amer Heart Assoc (AHA) BLS for the Health Care Professional American Red Cross (ARC) CPR for the Professional Rescuer American Safety & Health Institute (ASHI) CPR Pro</p> <p><i>May submit copy of official AHA, ARC or ASHI course roster in lieu of card.</i></p>	<p>Intentionally Left Blank!</p>
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SECTION V: ATTACH A COMPLETED & SIGNED CERTIFICATE APPLICATION (Green) CARD

Didactic, Attendance & Skills Verifications:

*I verify that the above EMT-Intermediate has satisfied all didactic, attendance & skills requirements during the period of his/her SC EMT certification. Official documentation in the form of **signed** class attendance rosters & skill verification sheets along with a completed and signed IST Re-certification Packet, are maintained as verification. I understand that any falsification of these records may be sufficient cause for SC DHEC Division of EMS to remove the certification of this individual as well as take disciplinary action,*

up to and including, cancellation of this SC licensed EMS Provider's IST Program and, revocation of the IST Training Officer's EMT certification. I understand that SC DHEC Division of EMS may request an audit of these records at any time.

Signature / Date

IST Training Officer

Signature / Date

Medical Control Physician

I affirm that ALL statements on this form are true to the best of my knowledge and that any incorrect or false information may be sufficient cause for SC DHEC Division of EMS to revoke my certification.

Signature / Date

EMT-Intermediate Re-Certification Candidate